

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-007598

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED MAR 7 1962

1. PLACE OF DEATH

a. COUNTY

St. Charles

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN St. CharlesLength of stay in 1b
3 yearsc. CITY
OR TOWN St. CharlesInside Limits
Yes ☒ No ☐c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION 919 Jefferson St.Inside Limits
Yes ☒ No ☐d. STREET
ADDRESS 919 Jefferson St.Reside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

Middle

Last

Alymer

L.

Dungan

4. DATE
OF DEATH

Month

Day

Year

February 22 1962

5. SEX

Male

6. COLOR OR RACE

White

7. Married ☒ Never Married ☐Widowed ☐ Divorced ☐

8. DATE OF BIRTH

4/16/03

9. AGE (last birthday)

68

IF UNDER 1 YEAR

IF UNDER 24 HRS

Mths 10

Days 8

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Int. Dore.

10b. KIND OF BUSINESS OR INDUSTRY

Decorator

11. BIRTHPLACE (City and state or country)

Bells, Tenn.

12. CITIZEN OF WHAT COUNTRY

USA

13a. FATHER'S NAME

Thomas Edgar Dungan

13b. MOTHER'S MAIDEN NAME

Mamie Hicks

14. NAME OF HUSBAND OR WIFE

Winnie Bailey Dungan

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mrs. Winnie Dungan, St. Charles

18. CAUSE OF DEATH (Enter only one cause per line
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Streptococcus Septicemia with

INTERVAL BETWEEN
ONSET AND DEATH

8 weeks

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

Subacute Bacterial Endocarditis and

DUE TO (c)

Perforation of Aortic Cusp

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☒ NO ☐

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from December 30, 1961, to Feb. 23, 1962 and last saw him alive on Feb. 22, 1962

Death occurred at 9:45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

Don 2. Randall, M.D.

22b. ADDRESS

220 S. 6th
St. Charles, Mo.

22c. DATE SIGNED

Feb. 23
196223a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE

Feb. 26, 1962

23c. NAME OF CEMETERY OR CREMATORY

Lake Charles Cemetery

23d. LOCATION (City, town, or county)

St. Louis County, Mo.

24. FUNERAL DIRECTOR

ADDRESS

Arthur C. Baue, St. Charles, Mo.

25. DATE RECD. BY LOCAL REG.

2/26/62

26. REGISTRAR'S SIGNATURE

Marcella Wilson

(Licensed Embalmer's Statement on Reverse Side)

AUG 8 1962

MAR 8 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John C. Smith

Licensed Embalmer No. 5145

P. O. Address St. Charles, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.